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| | 155784 | A. BUILDING 00<br>B. WING | 04/27/2011 |

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| F0000 | This visit was for Investigation of Complaint IN00089055.<br><br>Complaint IN00089055-Substantiated, Federal/State deficiencies related to the allegations are cited at F-385.<br><br>Survey dates: April 25, 26, and 27, 2011<br><br>Facility number: 012329<br>Provider number: 155784<br>Aim number: 201002500<br><br>Surveyor: Antoinette Krakowski, RN<br><br>Census bed type:<br>SNF/NF: 61<br>Total: 61<br><br>Census payor type:<br>Medicare: 40<br>Medicaid: 13<br>Other: 8<br>Total: 61 | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Sample: 3<br><br>This deficiency also reflects State findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed 4-29-11 Cathy Emswiller RN | | | |
| F0385 SS=G | A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.<br><br>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.<br>Based on interview and record review, the facility failed to ensure the physician sought hospital treatment for a resident with an infected stage III pressure ulcer as | F0385 | This plan of correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute | 05/20/2011 |

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| | indicated by foul odor, copious amounts of tan discharge, elevated temperature, lack of appetite, and progression into a stage IV pressure ulcer with severe tunneling. The lack of physician intervention resulted in the resident developing sepsis which required hospitalization and radical surgical debridement to remove infected flesh. This deficient practice affected 1 of 2 residents reviewed with pressure ulcers in a sample of 3.<br><br>Resident: # B<br><br>Findings include:<br><br>Resident # B's clinical record was reviewed on 4/25/11 at 3:15 P.M. and indicated he was admitted to the facility on 3/18/11 with diagnoses of, but not limited to: severe dementia, diabetes mellitus, anemia, peripheral vascular disease (poor circulation in extremities), and sacral decubitus ulcer.<br><br>A "(Hospital Name) Consultation Report," dated 4/06/11, indicated Resident # B's recent medical history which precipitated his placement at a long term care facility: "...The patient is an [age in years documented] gentleman who has had a difficult course over the last 6 weeks to 8 weeks. Essentially, he was found down | | admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1. Resident B is no longer at the facility.2. Current residents identified with pressure wounds have been reassessed by the physician and facility nurse with current status documented and treatment in the medical record.3. Facility staff educated to the expectation should a resident develop a change in wound status that signifies a potential infection such as but not limited to: worsening size of wound, change in odor, change in drainage, vital signs, or change in pain. The physician is to be notified of this change and in the event of potential inappropriate response, the DON will be notified for an alternate medical intervention including but not limited to transport to the local ER for further medical evaluation.4. Nurses will audit daily for any status changes that signifies a potential infection and need for physician notification and response.DON and/or designee will audit nurses compliance with physician notification, response time, and follow up notification of DON as needed for alternate medical interventions daily x 2 weeks, then 3 x week for 2 weeks, and | |

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| | after a fall around 2/02/11 and was admitted initially to (Name) Hospital with hypertension and a fall...He made progress, despite diagnosis of a subarachnoid hemorrhage (bleeding in the fluid-filled space on the surface of the brain) and some other issues during his recovery...ended up being dismissed with home PT (Physical therapy) and OT (Occupational Therapy). Unfortunately, he did not do well in that setting and ended up being admitted to (Name) Nursing Facility. There, he continued to have further issues...."<br><br>Resident # B's "Nursing Comprehensive Admission Data Collection and Assessment," dated 3/18/11, indicated: he was incontinent of both bowel and bladder, had right lower extremity impairment, needed limited assistance of two for bed mobility and transfers, and was totally dependent on staff for ambulation. An "Admission Skin Assessment," dated 3/18/11 indicated Resident # B was admitted to the facility with a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) pressure ulcer to the coccyx area (lower part of the spine located in the center of the buttocks) and a callus to left heel.<br><br>A Skin Grid, dated 3/20/11, indicated | | weekly thereafter. Identified trends will be reviewed in QA monthly for 3 months and then quarterly. Any identified non-compliance will result in 1 on 1 re-education including progressive disciplinary action up to and including termination.5. 5/20/11 | |

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| | resident # B's pressure ulcer was a stage III and measured 7.5 cm. (centimeters) in length, 4.0 cm. in width, and 0.1 cm. in depth. It further indicated the wound had a moderate amount of yellow drainage with odor and slough (dead tissue that is shed). A "Pressure Ulcer Healing Chart," dated 3/20/11, indicated the same data as the Skin Grid.<br><br>Nurse's Progress Notes indicated: 3/20/11 at 7:35 A.M., "Open area on the coccyx on top of an old healed pressure area found at 5:50 A.M. Area cleaned with N/S (normal saline) and covered. Physician notified and tx (treatment) order requested...2:20 P.M. Did not eat very much lunch, was medicated for heel pain earlier with relieve (sic). Dr. (Name) aware of bil. (bilateral) heel areas and coccyx, no new orders received..."<br><br>"Physician Notification" records, dated 3/20/11, indicated, 1:50 A.M.-"...Spoke with Dr. (Name), promised to see res. this morning during rounds...still waiting for TX (treatment) order to other skin areas...7:35 A.M.-"Old healed pressure area on the coccyx opened. L (length)-1.0 cm., W (width)-1.0 cm., tunneling 6 o'clock, depth 1. cm. x 0.5 cm. at the center of the area. Drainage red in color...Can we have order for calcium alginate (treatment) and apply duoderm | | | |

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| | (wound cover) to area...Date/Time of Onset of Symptoms: 3/20/11, 6:50 A.M. ...."<br><br>Nurse's Progress Notes indicated: 3/21/11 at 12:35 A.M.-"Dr. (Name) informed about low BP (blood pressure) 89/50, said he will see res (resident) in the A.M. ...1:50 A.M.-MD (Medical Doctor) notified about expanded skin area around the coccyx and bil. buttocks. Said he will see res in A.M. ...4:35 A.M.-c/o (complained of) bil. lower extremities pain. Rated pain at 9/10 (pain scale of 0-10 with 10 being severe), requested and was given pain med (medication)...9:00 A.M.-...has poor appetite...Evaluate (sic) by Dr. (Name) waiting for new orders...1:15 P.M.-New orders received and noted. Coccyx wound now measures 7.5 cm. x 4.0 cm. x < 0.1 cm., as superficial, no odor, mod (moderate) to sm (small) amt (amount) sero sang (serosanguineous) (thin and red) drainage...."<br><br>A Physician's Telephone Order, dated 3/21/11 at 8:00 A.M., indicated the following laboratory order: "BMP (basic metabolic panel), CBC (complete blood count), Prealbumin, B12 level, Air Loss Mattress (specialized mattress used to reduce pressure on body points). A second Physician Order, dated 3/21/11 at 8:00 | | | |

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| | A.M., indicated, "Prevalon Boots (protective covering) to feet, Allevyn heel (medicated heel treatment) to Lt (left) heel and change q (every) 72 hours...Santyl (a chemical debridement)...to coccyx. Cover with dry drsg (dressing) and change daily or prn (as needed) for soilage...."<br><br>A Physician's Progress Note, dated 3/21/11, indicated, "...Subjective: This patient is being seen...Review of Systems: ...Skin: Evidence of a stage II wound to the coccyx in a butterfly distribution to both buttocks. He also has heels with scaling. He also has a dry eschar (a black scab or dry crust that results from trauma) on the right heel.<br><br>Physician's Telephone Orders, dated 3/27/11 at 1:00 A.M. indicated, "Diagnosis: Fever, Orders: Tylenol 650 mg. (milligram) q 4 h (hours) prn (as needed) temp (temperature) > 100...6:00 P.M. Cipro (antibiotic) 250 mg. P.O. BID (twice daily) x 7 days for UTI (urinary tract infection)...."<br><br>Nurse's Progress Notes indicated: "3/27/11-Late entry: @ 7:30 A.M. -Medicated with Tylenol ii (2) P.O. (by mouth) per c/o T (temperature) 102.5...9:30 A.M.-Medicated per c/o bilateral leg pain...3:00 P.M.-...Moderate amount of yellow/bloody drainage with | | | |

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odor...7:00 P.M.-Resident had fever of 102. Medicated with tylenol...."

A Nurse's Progress Note, dated 3/28/11 at 10:00 A.M., indicated, "T-100.7...coccyx dsg (dressing) dry and intact, wound still has foul odor. Abt (antibiotic) continues for UTI...Still has some burning with urination...."

A "Physician Notification," dated 3/29/11 at 5:30 P.M., indicated, "...1. Need parameters for Cardizem (blood pressure medication) 30 mg. QID (four times/day) -B/P running low. Need orders for when to hold. 2. Family upset* res. was on Fentanyl (pain medication) patch 12 mcg. (microgram)...at home for chronic back pain...and it was D/C'd (discontinued) when he was admitted-THEY WANT HIM HACK ON IT-WILL NEED SCRIPT...Physician Response: Hold for SBP (systolic blood pressure) < [less than] 100. Fentanyl 12 mcg. q 72 hours."

"Physician's Telephone Orders," indicated: "3/30/11 at 11:40 A.M.- Tylenol Suppository 650 mg rectally q 4 hours PRN for temp > [greater than] 100 degrees for fever...4:00 P.M. ...Hold for SBP < 100. Fentanyl patch 12 mcg. change q 72 hours...."

A Nurse's Progress Note, dated 3/30/11 at

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| | 12:45 A.M. indicated resident # B had a fever with a temperature of 100.4 and was given Tylenol.<br><br>Nurse's Progress Notes indicated the following: 3/31/11 (no time given but documented after 5:00 P.M. note of 3/30/11 and prior to 10:20 P.M. note of 3/31/11), "...Coccyx dressing changed. Lg. (large) amnt (amount) tan foul smelling drainage from wound bed. Dk (dark) brown on coccyx, pink on buttocks. C/O Pain when touched...10:20 P.M.-c/o back/leg pain, repositioned with no imp (improvement), medicated for pain...4/01/11 at 12:00 A.M.-reassessed for pain and pain was reduced to 3/10 from 8/10 (pain scale)...1:40 A.M.-Res c/o of pain again, said he wants to go (to) the hospital, sister (Name) was called to talk to res. to be satisfied give medication time. (Dr. Name) was contacted, he ordered Tramadol (moderate pain medication) to be given. Res. already has this med. Med given per order...4:30 P.M. -Res. has increased pain over past few days. Fentanyl patch in place-prn pain meds as indicated...new TX order for coccyx to start tomorrow-to receive one unit PRBC (packed red blood cells) tomorrow...Drsg (dressing) to coccyx with brown drainage and odor... new order for Silvadene and charcoal. Change q day...." | | | |

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| | A Physician's Telephone Order, dated 4/1/11 at 1:00 P.M., indicated, "1. DC (discontinue) Santyl to coccyx. 2. Start-Cleanse area to coccyx with NS (normal saline), pat dry. Apply Silvadene (topical creme) and cover with charcoal drsg. Change daily and PRN...."<br><br>Review of a facility laboratory report, dated 3/21/11, indicated Resident # B's RBC (red blood cell)(a count of mature red blood cells in a specimen of whole blood) was 3.69 (low) with the normal being 3.90-5.90; HGB (hemoglobin) (transports oxygen to the cells) was 10.09 (low) with the normal being 13.0-17.3; and HCT (hematocrit)(a measure of the packed cell volume of red cells) was 34.6 (low) with the normal being 39.0-53.0. A follow-up lab was drawn a week later, 3/30/11, indicated his RBC remained low at 3.01; HGB remained low at 8.9; and HCT remained low at 27.2. His white blood cell count changed significantly from 9.13 (3/21/11) to a high 18.78 on 3/30/11 (normal 4.00-11.00) which is often indicative of infection.<br><br>A Physician's Telephone Order, dated 4/1/11 at 3:30 P.M., indicated, "1 unit packed cells...Type: Crossmatch...DX (diagnosis)-Anemia...."<br><br>Nurse's Progress Notes, dated 4/2/11, | | | |

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| | indicated, "...10:00 A.M.-Resident taken to (Hospital Name) per ambulance for blood transfusion...6:00 P.M.-...Returned from (Hospital Name)...Res. refuse meal-fluids offered and encouraged. Accepted poorly...."<br><br>Nurse's Progress Notes, dated 4/3/11, indicated, "12:40 A.M. ...Asked to be given sandwich. Could not eat the sandwich when offered to res. Took some H2O (water)...5:00 A.M.-C/O lower leg pain, rated pain at 7-8/10 (7 or 8 out of 10). Gave pain med per order...5:30 A.M. ...voiced relief from pain...8:00 A.M. ...Wound continues to have lots of sersang drainage. Wd (wound) bed has some yellow slough (necrotic or avascular in the process of separating from viable tissue. Usually soft, moist, and light in color; may be stringy). Areas blackened...9:00 P.M. ...TX in progress to coccyx and heel in progress. Drsgs. intact at this x (time). Foul odor remains-request to Dr. (Name) for wound vac D/T (due to) increased drainage...."<br><br>A "Physician Notification" form, dated 4/3/11 at 3:30 P.M., indicated, "Can we please have order for Wound Vac Drsg. to coccyx open area. Change q M-W-F (Monday-Wednesday-Friday) and PRN...Physician Response: Not at this time." | | | |

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| | Nurse's Progress Notes, dated 4/4/11, indicated, "1:45 A.M. Drsg. to the wound on the coccyx changed due to copious brownish drainage that soiled bed sheets discharging from the tunnel at the center of wound. Res in excruciating pain and crying out Lord have mercy. Dr. (Name) notified of copious drainage, order for wound vac requested as a F/U (follow up) to 2nd shift...1:50 A.M. Medicated for pain rated 10/10 (10 out of 10) to lower back and leg...2:30 A.M. Resting with eyes closed no S/S (signs or symptoms) of pain at present. 2:00 P.M. TX done as ordered-Lg. (large) amt. (amount) brown drainage. Pt. (patient) eating poorly-only bites of breakfast and lunch, < 5% both meals...Vicodin 5/500 (milligram) i (1) given at 10:40 (P.M.). C/O leg/back pain. Relief noted...."<br><br>Nurse's Progress Notes, dated 4/5/11, indicated, "4:50 A.M. During PRN drsg. change, soft area noted above open area. Fluctuates when palpated. Lge (large) copious (sic) amount tan foul smelling purulent (containing pus) drainage poured from wound. Drainage soaked 4 4x4's (4 x 4 inch gauze pads) and completely soaked a new ABD (abdominal) (a large thick) pad. Area cleaned with saline wnd (wound) cleaner and Santyl ointment applied. Covered with 4x4's and ABD. Pt. | | | |

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| | medicated for pain...2:00 P.M. Coccyx wound continues to drain copious amt. tan, foul serosang./purulent drainage. Order received for wound vac to area...Pt. continues to eat and drink poorly...did not eat any of meals...BP (blood pressure) meds held D/T BP 90/50 this A.M. Dr. (Name) notified...9:00 P.M. ...The wound on his coccyx is draining a large amount of brown fluid. Doctor notified it appears worse and should evaluate in A.M. ...11:30 P.M. Pt. calling out. States he's in pain. Attempted to give him vicodin crushed in applesauce but would not follow directions. Not following speekers (sic) eyes. Not appropriate in response to verbal stimuli. Unable to get BP with Durenap (electric blood pressure machine). BP 74/34 manual...Pt. spit applesauce with vicodin out. Continues calling out and moaning. Dr. (Name) notified. Ambulance called-(Ambulance Service Name) unable to send paramedics. 911 called. Pt. transported to (Hospital Name) ER (emergency room). Family notified."<br><br>A Physician Telephone Order, dated 4/5/11 at 5:00 P.M., indicated, Not eating well-Dietary consult...."<br><br>The "Physician Notification" Form, dated 4/5/11 at 11:30 (P.M.), indicated, "BP low. Pt change in LOC (level of | | | |

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| | consciousness). Will not answer questions, follow directions, calling out in pain but spit meds (crushed in applesauce) out when give. Not following directions to swallow. B/P very difficult to obtain. Hands cool to touch...Physician Response: Send to hospital."<br><br>Review of the "Skin Grid" indicated the coccyx wound remained a stage III from 3/20/11 through 4/4/11. The length changed considerably from 7.5 cm (3/20/11) to 8.3 cm (4/1/11) to 8.0 cm (4/4/11). The width changed from 4.0 cm (3/20/11) to 6.4 cm (3/23/11) to 7.3 cm (4/4/11) and the depth changed from 0.1 cm (3/20/11) to 3.0 cm (4/4/11). The color of drainage changed from Serosanguineous (3/23/11) to purulent (3/26/11) and remained so through 4/4/11. The odor changed from mild (3/23/11) to foul (3/26/11) and remained foul through 4/4/11. A "Pressure Ulcer Healing Chart" indicated the exudate (fluid that has been forced out of tissues or capillaries because of inflammation or injury) amount changed from a moderate amount (3/20/11) to heavy amount (3/29/11) and remained so through 4/4/11.<br><br>Resident B's "Braden Risk Assessment Scale," dated 3/18/11, indicated he was at high risk for the development of a pressure ulcer. | | | |

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RN # 3 indicated in an interview on 4/24/11 at 3:00 P.M. that all wound documentation is on the wound sheets (Skin Grid) themselves. She further indicated she does not do narrative charting on the wounds.

Resident # B's clinical record lacked any documentation by his physician except for the progress note dated 3/21/11 and a statement on 4/5/11 which indicated, "Pt seen. Note dictated."

On 4/25/11 at 3:10 P.M., the Director of Nursing (D.O.N.), when queried regarding the lack of Physician Progress Notes in Resident # B's clinical record, indicated she spoke with Dr. (Name) just last week and he reported to her that he dictated his notes and a copy would be sent to the facility. She indicated she would contact his office and have them fax the notes over to the facility. She also indicated that the doctor made weekly rounds in the facility.

RN #4 indicated in an interview on 4/25/11 at 4:30 P.M. that she looked at Resident # B's wound on or about 4/1/11 and recommended a change in treatment from the Santyl to Silvadene and a charcoal dressing. "The wound wasn't draining when I saw it. The nurse

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| | removed the dressing and the wound looked clean, but you could see this membrane in the center of the wound (indicated the size of a small tangerine with her fingers). It was mushy under that membrane and the fear was that it could be affecting the bone. You could tell there was something more going on then you could actually see."<br><br>RN # 3 indicated on 4/25/11 at 5:00 P.M., that she had asked Physical Therapist #5 to look at the wound after the first treatment had begun. She indicated he had said the wound was not appropriate for debridement. She further indicated nursing had notified the doctor of changes with the wound.<br><br>The D.O.N. presented a copy of a hand-written Physician Progress Note on 4/26/11 at 10:30 A.M. It was in response to the previous day's request and was dated 4/26/11. The Progress Note indicated, "Pt. was evaluated on 4/4 for wound care. I reviewed all records and we changed dressing on 4/1/11 to topical Silvadene. Pt TX daily and no purulent drainage noted at that time. Pt was given charcoal dressing for odor. Pt became septic on (blank) and sent to (Hospital Name) ER...Wound was present prior to admission. We ordered air mattress, turn sched. (schedule), dietary consult. On | | | |

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| | protein. Pt was non-compliant with interventions."<br><br>Resident # B's hospital History and Physical, dated 4/06/11, authored by the facility (nursing home) physician indicated, "...History of Present Illness: The patient is being seen on rounds today here. He came into the emergency room early this morning. He was previously at (Nursing Home Name). He comes in with hypotension (low blood pressure). I do not know anything about this gentleman, but he came in cachectic (poor health and malnutrition) with severe sacral ulcer, acute renal failure with dehydration, hypokalemia (low potassium)...We are seeing him this morning with mental status changes not responding to me. I do not know him at all. He was recently apparently placed in the ECF (extended care facility)...He had a purulent draining material from his wound...Physical Examination: ...Abdomen: Soft. He has a foul smelling order (sic) to the sacrum with an actively draining brown fluid. He has a sacral stage IV (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling) coccyx ulcer, which was present prior to this admission...Diagnoses: 1. Sepsis. 2. Bacteremia. 3. Electrolyte | | | |

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| | abnormalities...5. Volume depletion. 6. Anemia. 7. Stage IV wound...Plan: ...3. Rehydration with fluids of normal saline 125 an hour. 4. Two units of packed cells today. 5. Wound care regarding this wound...."<br><br>A Emergency Department Report, dated 4/06/11, indicated, "...The patient at extended care facility was noted to have hypotension with systolic blood pressure in the 80s, was sent to the Emergency Department. They also state today the sacral ulcer started draining putrid material. They deny any fevers or chills...Skin: There is a very large area to the lower back in the midline consistent with a sacral ulcer that is actively draining very foul odorous brown fluid...My attention to patient's sacral ulcer, I have expelled myself 30 ml (milliliters) of purulence; however, nurse states that prior to my evaluation, they had also expressed quite amount of material as well...Next, my attention to his pain, the patient was moaning severely...I have made them (family) aware of patient's grave status that he is fairly critical...."<br><br>A "Consultation" Report, dated 4/07/11, indicated, "...Dr. (Name) assumed care and consulted me by phone yesterday to see this patient because he had a very foul-smelling large necrotic decubitus | | | |

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| | ulcer on his coccyx and sacrum...the patient was stabilized and taken to surgery earlier today where the wound was debrided and significant tissue was lost due to necrosis. The operative note describes the size of the wound, which is dramatic...I am now seeing the patient to suggest appropriate antibiotic therapy...Impression: Dehydration and presumed sepsis syndrome related to the severely necrotic infected coccyx and sacral decubitus wound...there was bone palpable in the base; as one might expect suggesting there would be underlying osteomyelitis (infection of the bone)...."<br><br>The "Operative Report," dated 4/07/11, indicated, "...We made an elliptical incision around the area of the sacral decubitus ulcer which had necrotic tissue and a significant amount of purulent material underlying the surface of this wound. As we debrided we noted that this wound continued to track significantly to the left lateral side and continued to uncover further and further areas of rather putrid smelling necrotic tissue and purulent material. In the end, once we debrided this tissue...we found that this wound tracked almost 15 cm x 8 cm towards the lateral side and extending almost all the way to his left hip...I spent around 25 minutes visiting with the family discussing with them the severity | | | |

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| | of this wound and the slim likelihood of him ever healing this process...."<br><br>This federal tag relates to Complaints IN00089055.<br><br>3.1-40(a)(2) | | | |